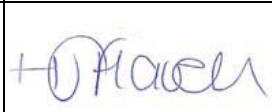
The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
13 October 2022

Agenda item	184/22			
Report Title	NHSR Clinical Negligence Scheme for Trusts (CNST) Report			
Executive Lead	Hayley Flavell, Director of Nursing			
Report Author	Tom Baker, Deputy Director of Ops, W&C Division			
	Link to strategic goal:		**Link to CQC domain:**	
	Our patients and community	√	Safe	√
	Our people	√	Effective	√
	Our service delivery	√	Caring	√
	Our governance	√	Responsive	√
	Our partners	√	Well Led	√
	Report recommendations:		**Link to BAF / risk:**	
	For assurance	√	BAF 1, BAF 2 BAF 3, BAF 4 BAF 7, BAF 8	
	For decision / approval	√	**Link to risk register:**	
	For review / discussion		CRR 15	
	For noting			
	For information			
	For consent			
Presented to:	*2022.08.23: Women's and Children's Divisional Committee* *2022.08.31: Quality & Safety Assurance Committee*			
Executive summary:	SaTH is a participant in year 4 of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS), which is operated by NHS Resolution (NHSR) and supports the delivery of safer maternity care. This paper sets out SaTH's progress to date in demonstrating compliance with the actions in their current format and plans for the remainder of the reporting period. It also includes information to evidence the closure or partial completion of several Safety Actions, which must be approved by the Board of Directors (as opposed to any sub-committee).			
Appendices	Appendix 1: Digital Strategy – Maternity Appendix 2: Locally Agreed Safety Intelligence Dashboard			
Executive Lead		Hayley Flavell Director of Nursing The Shrewsbury & Telford Hospital NHS Trust 27 September 2022		

1.0 Introduction

1.1 SaTH is a member of the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme (CNST MIS), which is regulated by NHS Resolution (NHSR) and is designed to support the delivery of safer maternity care.

1.2 The scheme incentivises ten maternity safety actions. Trusts that can demonstrate they have achieved all ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

1.3 The purpose of this paper is to provide the Board of Directors with:

1.3.1 Assurance that SaTH is compliant with the standards it is obligated to have attained by this point.

1.3.2 Details of the standards that must be evidenced between now and the reporting deadline.

1.3.2.1 This had been set at 5 January 2023 in the most recent guidance issued by NHS Resolution, but the organisation has notified the Trust that the deadline is due to be further extended – probably to February 2023.

1.3.2.2 **This will affect the planned sign-off process; details will be conveyed to the Board of Directors as soon as possible.**

1.4 This paper comprises two appendices:

1.4.1 **Digital Strategy – Maternity** (Safety Action 2 – for approval)
1.4.2 **1Q2022-23 Locally Agreed Safety Intelligence Dashboard** (Safety Action 9; for assurance and approval).

2.0 Overall Progress Status

2.1 The below chart shows a CNST completion rate as at August 2022 (including compliance with the standards and accrual of supporting evidence) of 39% 'Evidenced and Assured', 38% 'Delivered, Not Yet Evidenced' and 23% 'Not Yet Delivered'.

2.2 The plan is on track for delivery within the most recently published deadline of noon on Thursday 5 January 2023, and QSAC have accepted a sign-off procedure plan

on behalf of the Board of Directors (this will have to be amended, as referenced in paragraph 1.3.2.2. once further details are known. Nonetheless, some risks to delivery do still exist, and these are highlighted below in section 10.

3.0 Safety Action 1: "Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?"

3.1 SaTH is compliant to date with reporting to the MBRRACE-UK website.

3.2 The Board of Directors (BoD) has received a report each quarter since August 2021 that includes details of the deaths reviewed and the consequent action plans. This must continue up to the CNST deadline.

3.3 The most recent report (Quarter 1, 2022-23) was presented by the Director of Midwifery (DoM) to the BoD's Meeting in Private in August 2022. Going forward, an automated reporting feature within PMRT will be used to furnish this report.

3.4 **Progress Status: On Track**

4.0 Safety Action 2: "Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?"

4.1 The revised requirement for Safety Action 2, standard 1 is that Trusts have an up-to-date digital strategy for their maternity services which aligns with the wider Trust Digital Strategy and reflects the 7 success measures within the What Good Looks Like Framework[1].

4.1.1 Maternity, Fertility and Neonatal Services and divisional leadership, partnering with the Trust's Digital Leadership team (including the Digital Transformation Officer and Chief Information Officer) have produced this strategy, which has been designed to complement the wider Trust strategy.

[1] https://transform.england.nhs.uk/digitise-connect-transform/what-good-looks-like/what-good-looks-like-publication/

4.1.2 This proposed Maternity Digital Strategy is attached at **Appendix 1**. The strategy has been approved by the Women's and Children's Divisional Committee, QSAC and the LMNS / ICB.

4.1.3 The Board of Directors are requested to **review and discuss** this, and, if content, **approve** it.

4.2 Regarding standards 2-7: The April 2022 updates to the Divisional Committee, QSAC and other forums noted that SaTH was experiencing issues with data upload to the Maternity Services Data Set (MSDS).

4.2.1 Fortunately, this position has been much improved through ongoing staff training (thereby improving quality of data entered) and resolution of configuration issues. Based on the Trust's own assessment of its data upload for July 2022, the following points should be noted:

4.2.1.1 All 11 Clinical Quality Improvement Metrics (CQIM's) appear to have been uploaded to the requisite standard

4.2.1.2 Body Mass Index, Complex Social Factor and Personalised Care Plans have all been uploaded for over the pass mark of 90% of all women.

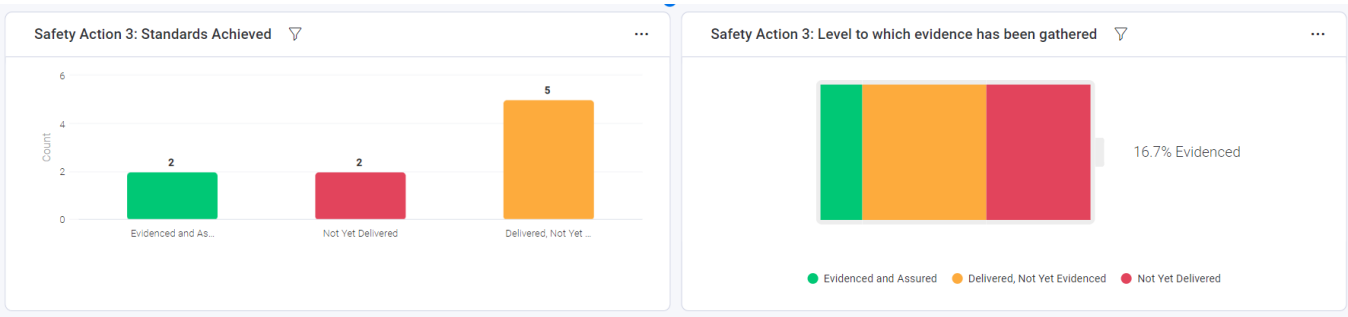
4.2.1.3 Ethnicity data for the period has been captured for >90% of service users.

4.2.2 Is it therefore likely that this Safety Action will be achieved. However, ongoing data issues continue; this appears to be a systems fault between SaTH and the NHS. The standard can still be attained if SaTH can evidence continued dialogue and attempted resolution with NHS Digital, which is in place. However, until definite proof that the data standards have been attained, the status must remain 'at risk'. Confirmation will be reported to the Board of Directors via QSAC, as soon as it is available.

4.2.3 It should also be noted that the data that Trusts upload to the MSDS is not published by NHS Digital for at least two months pending receipt, hence it will not be possible to confirm definitively whether this safety action has been attained until October 2022 at the earliest.

4.3 **Progress Status: At Risk**

5.0 Safety Action 3: "Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?"



5.1 The Trust has Transitional Care Service pathways in place and continues to achieve the national target of ATAIN

5.2 A new standard was introduced in the May 2022 update to the effect that a data recording process (electronic and/or paper based) for capturing all term babies transferred to the neonatal unit, regardless of the length of stay, is in place. This was implemented within the mandatory deadline of 16 June 2022.

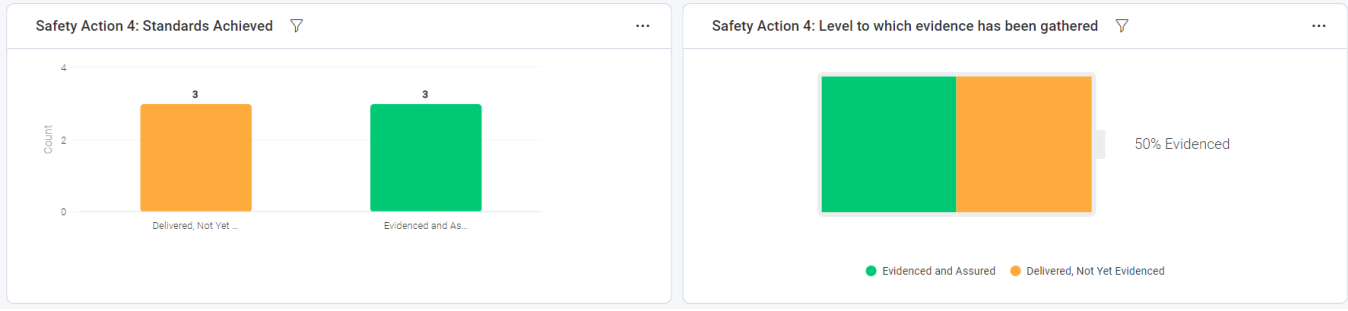
5.3 Standard b) requires there to be a quarterly audit of transitional care; the report for Quarter 1 2022-23 has been accepted by QSAC at their August 2022 meeting. The paper also evidences compliance with standards d) (confirmation that a database exists in which all transitional care activity is recorded) and standard e) commissioner returns are available for ICS scrutiny upon request.

Standard c) was adjusted in the May 2022 guideline and now states that “A data recording process (electronic and/or paper based for capturing all term babies transferred to the neonatal unit, regardless of the length of stay, is in place. This has been implemented, with the proforma recommended by NHS Resolution being used at a weekly meeting, which discusses case-by-case.

5.4 Similarly, Standard f) requires a quarterly audit of ‘Avoiding Term Admission into the Neonatal Unit’ (ATAIN) to be conducted – the report for Quarter 1 2022-23 has been accepted by QSAC at their August 2022 meeting.

5.5 **Progress Status: On Track**

6.0 Safety Action 4: “Can you demonstrate an effective system of clinical workforce planning to the required standard?”



6.1 **Standard a**). The Obstetrics workforce paper was delivered to QSAC at their February 2022 meeting, and the associated audit of consultant attendance where required has been conducted and found to be compliant; this completed Standard a) Part 1.

6.1.1 The May 2022 updated requires standard a) Part 1 to be reviewed at least once since the re-launch and reported to the Board of Directors (via QSAC) and to the LMNS.

6.1.2 The Clinical Director for Obstetrics has reviewed the paper and confirmed that it stands, with no need for amendment. Detail to support this finding was provided in an update paper, which was accepted by QSAC at their August 2022 meeting.

6.1.3 The Board of Directors are requested to **take assurance** that this closes out Standard a) part 1.

6.1.4 As regards Standard a) Part 2 ("*Units should monitor their compliance of consultant attendance for the clinical situations listed in this document [RCOG Roles and Responsibilities of a Consultant] when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance. Trusts' positions with the requirement should be shared with the Trust board, the board-level safety champions as well as LMNS*"):

6.1.4.1 This was subject to the Ockenden Case Notes audit in October 2021 and has been accepted as a standing audit as part of the revised Maternity Forward Audit and Assurance Plan, from which assurance will be taken. A repeat audit date has not been set at this time, but confirmation will be provided as soon as this has been established.

6.1.4.2 In the meantime, the Consultant Lead for Investigating Incidents monitors compliance of this attendance and this is noted at the Neonatal and Obstetric Incident Review Meetings. There have been no breaches or near misses to date.

6.2 **Standard b).** Evidence of achieving ACSA Standard 1.7.2.1 was provided to QSAC in the April 2022 update in the form of anaesthetics consultant on-call rotas up to December 2021.

6.2.1 The May 2022 re-launch requires this data to be provided for six consecutive months up to and including January 2022. This has been done, and the standard remains compliant, hence this part of the action has been closed out.

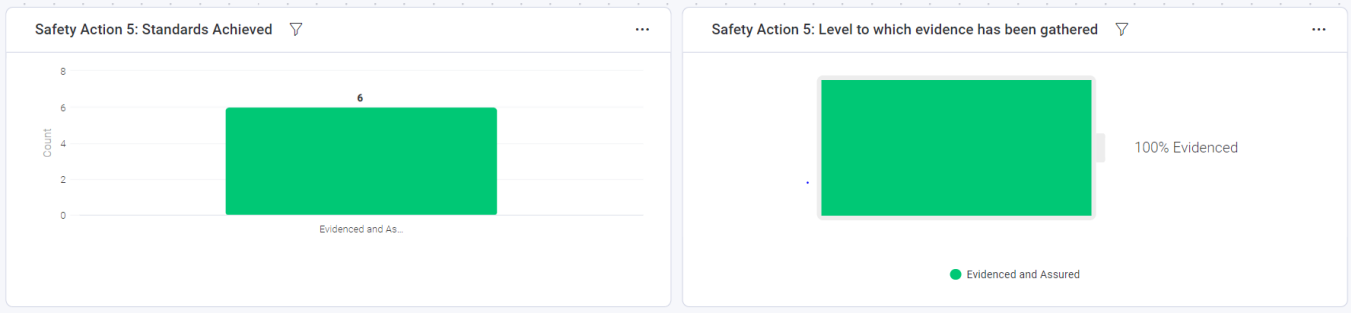
6.2.2 The rotas for this period have been provided to QSAC and show that, throughout this period, there was an obstetric anaesthetist on call 24/7 every day of the year. There is a consultant that can be called every day/ night.

6.3 **Standard c)**. The evidence to show that SaTH has a BAPM-compliant Neonatal Medical Workforce has already been provided to QSAC in April 2022. There has been no change to this standard in the May 2022 re-launch hence it remains complete.

6.4 **Standard d)** A separate paper outlining the level of compliance with Safety Action 4 standard d) (Neonatal Nursing Workforce) is being drawn up and will be delivered to QSAC no later than November 2022.

6.5 **Progress Status: On Track**

7.0 afety Action 5: "Can you demonstrate an effective system of midwifery workforce planning to the required standard?"



7.1 This action requires two papers covering midwifery staffing to be provided to the Board of Directors during the course of the reporting year; the first was provided in November and the second was included in the previously mentioned "Ockenden Review into Maternity Services – 1 year on" paper which was received by the Board of Directors in February 2022.

7.2 This action had been completed at the time of the April 2022 QSAC update. However, the May 2022 re-launch has an additional standard (b), which requires the Board of Directors to evidence that the midwifery staffing budget reflects establishment as calculated in a systematic, evidence-based process to calculate midwifery staffing establishment.

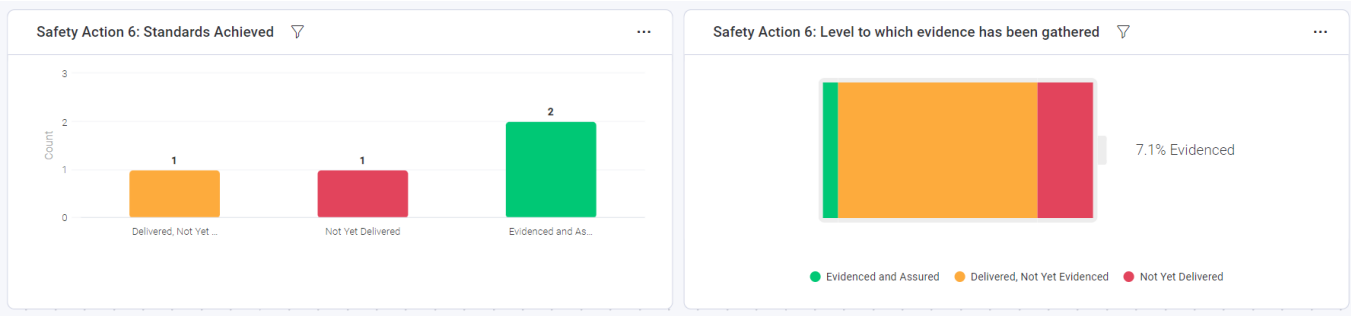
7.3 The latest update, dated 14 July 2022 and covering Quarter 4 of 2021-22 was produced by the Director of Midwifery, and has also been received by the Board of Directors and QSAC. This paper is re-attached **for information** at **Appendix 7**. A further paper covering Quarter 1 2022-2023 (April to June 2022) has been produced by the DoM and will be shared with QSAC at their September meeting.

7.4 SaTH implements the process referenced here by commissioning the Birthrate Plus™ tool. In the light of Immediate and Essential Action 2.4 from the final Ockenden Report, the Director of Midwifery has decided to re-commission this assessment, which is expected to have been completed by October 2022.

7.5 In compliance with Standard b), the most recent Birthrate Plus report was received by the Board of Directors on 10 June 2021 and approval to fund the posts accordingly was given. This standard has therefore already been satisfied, notwithstanding point 7.4 above.

7.6 **Progress Status: Complete**

8.0 Safety Action 6: "Can you demonstrate compliance with all five elements of the Saving Babies' Lives (SBL) care bundle version two?"



8.1 This is one of the largest and most complex of all the Safety Actions because it comprises the five elements of SBL:

- 8.1.1 Reducing smoking in pregnancy.
- 8.1.2 Risk assessment, prevention and surveillance of pregnancies at risk of foetal growth restriction (FGR)
- 8.1.3 Raising awareness of reduced foetal movement (RFM)
- 8.1.4 Effective fetal monitoring during labour.
- 8.1.5 Reducing preterm birth.

8.2 Pertaining to Element 1, and as highlighted in the April 2022 update to QSAC, the Trust is still experiencing difficulty in achieving the standard required of >80% women receiving CO monitoring at 36 weeks. The causes of this had been due to data entry problems with the Electronic Patient Records System, now resolved, as well as national and local shortages of the disposable tubes through which the service users must breathe in order to give the reading. This remains a problem, despite ongoing work to resolve the supply issue.

- 8.2.1 Encouragingly, CO monitoring booking is now routinely being monitored to for above 80% of women (i.e. the target has been attained for the last four consecutive months), and in July 2022 and August 2022 this target was also reached for the 36 week appointment.

- 8.2.2 In order to achieve compliance with this standard, SaTH must achieved >80% on both metrics for four consecutive months before the end of the reporting period in January 2023 (confirmation of the revised deadline, possibly February 2023 has not been provided, hence as of now, the Trust is following the May 2022 guidance). Therefore, whilst the trajectory is positive, this action must still be considered 'at risk'.

8.3 In accordance with the requirements of Elements 2 and 5, the quarterly audits continue to be produced and reported in full to QSAC.

- 8.3.1 The Board of Directors is asked to take assurance from the fact that smoking rates in pregnancy are falling in our local communities at SaTH, detection and management of babies less than the 3rd centile remains better than the Perinatal Institutes national GAP user average

- 8.3.2 However, detection and management of babies born between the 10th and 3rd centile is below the Perinatal Institutes national GAP user average. This is a concern, hence is a focus for 2022/2023.

8.4 Finally, the Board of Directors is asked to **note**, and specifically confirm **that**, in compliance with standard 5 e. SaTH:

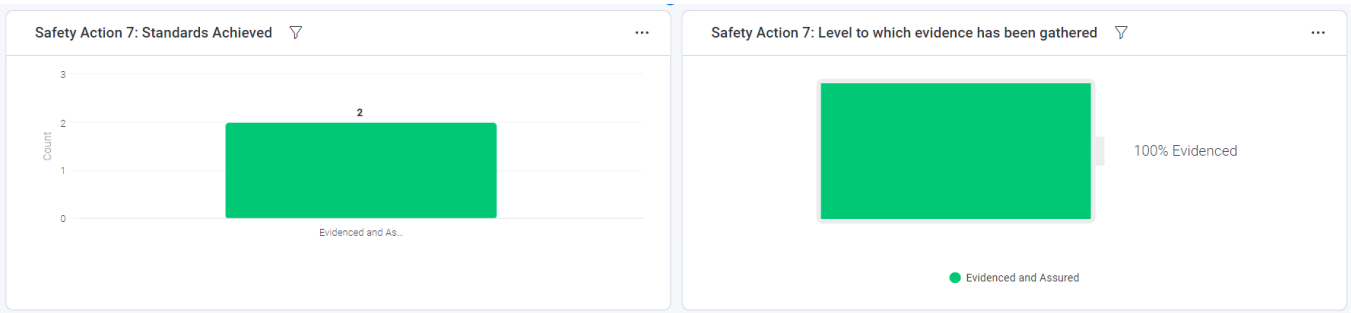
8.4.1 Has a dedicated Lead Consultant Obstetrician with demonstrated experience to focus on and champion best practice in preterm birth prevention. Compliance evidence (job plan attached for Mr Guy Calcott) has already been accepted by QSAC.

8.4.2 Women at high risk of preterm birth have access to a specialist preterm birth clinic where transvaginal ultrasound to assess cervical length is provided (Evidence comprising preterm clinic plans and description has already been accepted by QSAC).

8.4.3 An audit of 40 consecutive cases of women booking for antenatal care has been completed to measure the percentage of women who are assessed at booking for the risk of preterm birth and stratified to low, intermediate and high-risk pathways, and that this complies with NICE guidance (The audit of preterm birth risk assessments has already been accepted by QSAC).

8.5 **Progress Status: At Risk (due to the above-mentioned risk relating to CO testing targets for mothers at 36 weeks; all other action are 'on track').**

9.0 Safety Action 7: "Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?"



9.1 The productive partnership between SaTH and the Maternity Voices Partnership continues to yield important benefits for service users and staff alike.

9.2 All of the evidence requirements for Safety Action 7 has now been secured, with the receipt of the following two items:

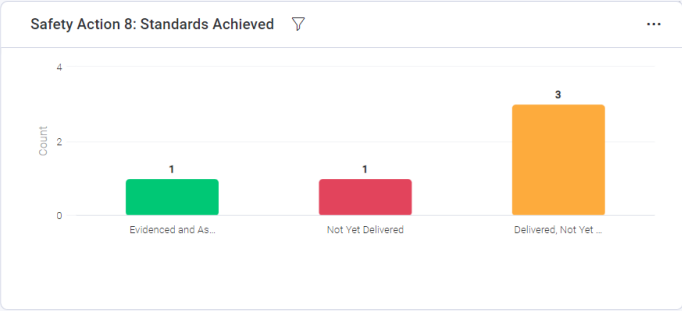
9.2.1 Written confirmation from the MVP service user chair that they and other service user members of the MVP committee are able to claim out of pocket expenses, including childcare costs in a timely way**,** and that the Chair receives remuneration in line with Trust processes and reflective of the commitment.

9.2.2 Evidence that the MVP is prioritising hearing the voices of women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation, given the findings in the MBRRACE-UK reports about maternal death and morbidity and perinatal mortality.

9.2.2.1 The MVP has produced a paper titled '*Engagement with Seldom Heard Groups, including the Black, Asian and Minoritised Ethnic communities*.' This included a number of proactive proposals for LMNS consideration, and has been approved by that forum.

9.2.2.2 **Progress Status: Complete**

10.0 **Safety Action 8: "Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4? In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum foetal surveillance and new-born life support, starting from the launch of MIS year 4?**



10.1 It was reported in the April 2022 QSAC update that this action was at risk. Due to successful mitigation since this report and the extended CNST deadline announced in the May 2022 update, the action is largely back on track, and most groups are compliant to at least the 90% level. However, due to new starters and expiry, some groups have fallen back in compliance with some training; this is being addressed as a priority. It should be noted that a PrOMPT training day scheduled for 19 September 2022 had to be cancelled in respect to the funeral of Her Late Majesty the Queen.

10.2 There is a requirement that 90% of each relevant maternity unit staff group have attended an 'in-house' one day multi-professional training day, to include maternity emergencies starting from the launch of MIS year four in August 2021. As of 31 July 2022, SaTH has achieved the following statuses, and is on track to reach the 90%:

10.2.1 Midwives: 95%
10.2.2 Obstetrics Consultants: 100%
10.2.3 Other doctors: 100%
10.2.4 Obstetrics anaesthetists: 100%
10.2.5 Healthcare assistances / midwifery service assistants: 90%

10.3 The training must also include antenatal and intrapartum foetal monitoring and surveillance, starting from the launch of MIS year four in August 2021. As above, statuses as of 9 June 2022 are:

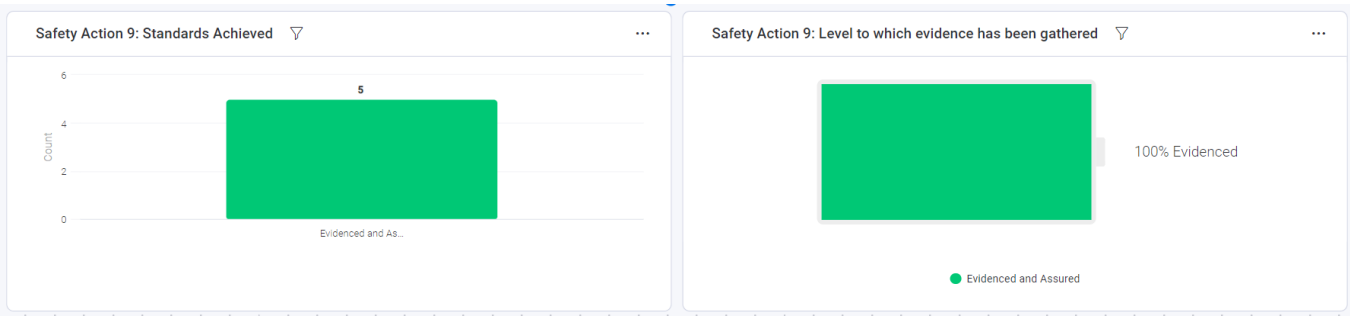
10.3.1 Midwives: 95%
10.3.2 Obstetric Consultants: 100%
10.3.3 Other Doctors: 78% (training underway to bring this back to above 90%)

10.4 Neonatal Life Support (NLS) training rates have also all exceeded the 90% minimum limit for Neonatal Nurses and Doctors at this time, but has fallen to 79% for in-scope midwives. A plan to bring this back to above 90% is underway.

10.5 A full report, to include line-by-line evidence, will be provided to QSAC no later than November 2022 and a summarised version of this report will be provided to the Board of Directors' at their seminar session on 1 December, to inform final declaration.

10.6 **Progress Status: At risk (must be considered as such until all groups have attained the required percentage of staff to be trained)**.

11.0 Safety Action 9: "Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?



11.1 This action has now been fully evidenced, with the group having been apprised with all necessary CNST documentation and reporting to date.

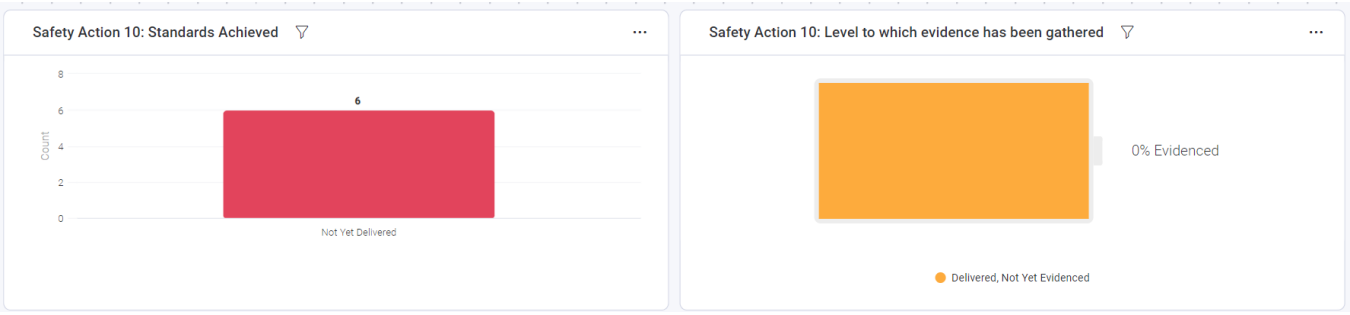
11.2 The Group continue to meet on a monthly basis, with a 'walkabout' of a clinical area conducted at least every second month.

11.3 The group now benefits from the inclusion of a new Non-Executive Director Safety Champion, Professor Julie Green.

11.4 The most recent 'Locally Agreed Safety Intelligence Dashboard' as produced by the Safety Champions, is provided at **Appendix 2** for **information** and **approval** of the Board of Directors.

11.5 **Progress Status: Complete (quarterly dashboard to continue to be provided to QSAC and the Board of Directors)**.

12.0 Safety Action 10: "Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) scheme for 2021/22?



12.1 This Safety Action relates principally to the work of the Divisional Quality Governance Team, supported by the Assistant Director of Nursing, Quality Governance. As with Safety Action 1, the need to report appropriately to the (HSIB) and the NHS Resolution Early Notification Scheme (ENS) is ongoing, hence this action is never 'completed'.

12.2 Notwithstanding this, the action was presented as having been closed out in the April 2022 report to QSAC, there having been evidence of compliance with HSIB and ENS reporting and Duty of Candour for the period concerned, namely financial year 2021-22.

12.3 The reporting period has been extended to December 2022 under the terms of the May 2022 update. Accordingly, a refreshed paper evidencing compliance will be brought to QSAC in November 2022, with a summary of this being provided to the Board of Directors and LMNS / ICS to inform final declaration at the Board Seminar Session on 1 December 2022.

12.4 **Progress Status: On Track**

13.0 Ongoing Risks to Delivery

There is a risk that…	The risk is caused by…	The potential impact of the risk is…	The mitigation in place is…
The Maternity Services Data Set may be incomplete (SA2), with one quality metric currently not achieved	Insufficient number of data sets collected for service user ethnicity on booking	A failed data set for the month of July causing failure of Safety Action 2	1. All 11 Clinical Quality Improvement Metrics appear to have been hit 2. The sub-metric for ethnicity is being re-gathered as a retrospective exercise; >87% had been reached and the remaining ~3% is feasible.
Trust may miss SBL CO testing targets for mothers for the 36-week CO monitoring). (SA6)	Configuration issues between the Badgernet and Medway EPRs; a shortage of breathing tubes in Spring 2022.	If we don't achieve a minimum of 80% compliance over a 6 month for the 36-week CO monitoring the Trust will fail Safety Action 6.	1. CO testing at booking now achieved routinely 2. In June 2022, CO monitoring target was also achieved for 36- week point. 3. If this trajectory or level continues for a further 3 months, standard will be achieved.
Trust may miss 90% target for Neonatal Life Support training for midwives and for fetal monitoring for 'other doctors'.	Training having expired for some colleagues within these groups	Failure of Safety Action 8	1. Training scheduled for these colleagues within deadlines 2. SaTH expect to achieve this Safety Action, but cannot guarantee this at this time.

14.0 Summary

14.1 SaTH is mostly on track to achieve CNST MIS Year 4 in its latest format, though some risk to delivery for Safety Actions 2, 6 and 8 remains.

14.2 In the April update to QSAC, under the October 2021 guidance, SaTH was able to evidence that three of the of the ten actions had been completed, four were on track, and three at risk (mitigation in place).

14.3 The latest status (due to amended standards and revised deadlines, with associated requirement to evidence for a longer period of time), the Trust can report that four actions are 'on track', three are 'complete' and a further three 'at risk'.

15.0 Summary of Safety Action completion Statuses:

Safety Action #	Completion Status
1	On Track
2	At Risk
3	On Track
4	On Track
5	Complete
6	At Risk
7	Complete
8	At Risk
9	Complete
10	On Track

16.0 Actions requested of the Board of Directors:

16.1 **Note** that the CNST reporting deadline will change again, probably to February 2023, and that a revised sign-off process will be put forward by the Women's and Children's Division to QSAC.

16.2 **Review and discuss,** and, if content, **approve** the Digital Strategy for Maternity (Appendix 1)

16.3 **Approve** the Locally Agreed Safety Intelligence Dashboard (appendix 2).

16.4 **Note** and specifically **confirm** that SaTH:

16.4.1 Has a dedicated Lead Consultant Obstetrician with demonstrated experience to focus on and champion best practice in preterm birth prevention

16.4.2 Ensures women at high risk of preterm birth have access to a specialist preterm birth clinic where transvaginal ultrasound to assess cervical length is provided (Appendix 10 part b: preterm clinic plans and description

16.4.3 Has conducted an audit of 40 consecutive cases of women booking for antenatal care to measure the percentage of women who are assessed at booking for the risk of preterm birth and stratified to low, intermediate and high risk pathways, and that this complies with NICE guidance

16.5 **Take assurance** that SaTH are largely on track for delivery of CNST MIS Year 4, but **note** the ongoing risks to delivery.

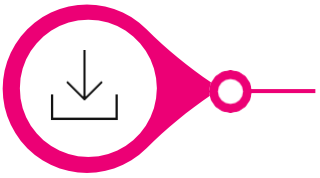
Appendix 1:
Our Digital Strategy supports the Maternity Transformation Programme

The Shrewsbury and Telford Hospital NHS Trust

This Trust has embarked on a Maternity Transformation Programme. This aims to achieve sustainable improvements within maternity services, whilst focussing on implementing and embedding all actions outlined in the findings of the Ockenden Report in March 2022.

This Digital Strategy aims to promote safe and effective care across the Trust, whilst supporting the objectives of the Maternity Transformation Programme (MTP). We will continue to build upon the successful introduction of core solutions such as Viewpoint and BadgerNet, and will respond to opportunities to use digital to enable the implementation of actions within the Ockenden Report. Our future delivery means giving our service users greater access to their records through the Patient Portal and putting in information screens in the maternity department as well as throughout the hospital sites. We will continue to work with our Maternity Voices Partnership to ensure we have digital inclusion, our solutions are designed with our service users' needs first and we continue to report our progress through tools such as Monday.com. Our aim is to use digital to support clinicians, midwives and service users to have a safe and positive experience of our care.

Maternity planned deliverables

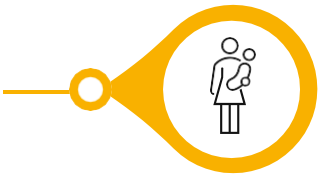


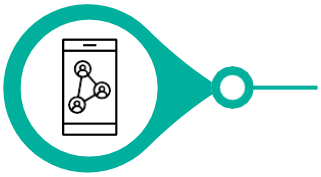
Viewpoint

Ultrasound reporting and image management solution.

BadgerNet

Total continuity of maternity care across settings beyond the hospital and out into the community using a fully-inclusive solution, which captures and records information for women antenatally and postnatally, as well as during the intrapartum period.



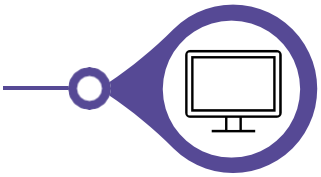


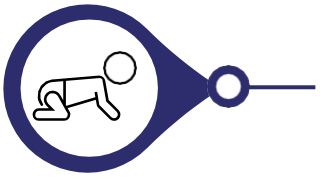
ImproveWell App

Enhancing staff engagement and boosting morale, using the innovative idea hub, push notifications, pulse surveys and sentiment tracker features within the platform.

Maternity Whiteboard

Introducing screens to share key information with clinicians 'at a glance' to improve service user flow, reduce errors and releasing staff time to provide care.





Fertility Viewpoint scanners

System and scanners to support fertility management.

Digital transformation will improve our maternity care

The Shrewsbury and Telford Hospital NHS Trust

Project	Objective(s)	How this will deliver excellent care for service users	How this will provide an environment that our staff can thrive in	How this will make us more effective and efficient as an organisation and partner
Ultrasound reporting and image management *(Viewpoint)*	Provision of a secure, accessible image management platform.	Best possible interpretation of images; user-friendly solution	Efficient access to images with minimal non-value-adding processes	Where applicable / appropriate, easily facilitated image sharing with partners.
Maternity records system *(BadgerNet)*	Electronic Patient Record system for end-to-end maternity care.	Mobile app encourages engagement of the service-user with access to appointment information and pregnancy advice.	Improved handover of care between ward areas. Consistent approach to maternity documentation.	Efficient and comprehensive transfer of service user documentation between neighbouring trusts.
Neonatal records system *(BadgerNet)*	Implementation of full Badgernet EPR for neonatal care.	Integrated systems encompassing maternal and neonatal notes.	All information integrated into one system.	Ability for whole team to access all information. Reduction in current duplication across several systems.
Maternity Whiteboard	Replace handwritten handover board with an integrated, contemporaneous and editable interface to the EPR system.	Reassurance that all staff have timely access to the service-user's situation to better respond to their needs.	Clear and consistent presentation of the service-user's situation and needs to make handovers, and the reaction to acute events, as efficient as possible.	Improve timeliness of interventions through visibility and standardisation of service-user details.
Maternity and Neonatal Dashboard Maturity	Ensure accurate data is provided of quality and performance indicators in maternity.	Demonstrate safety metrics and benchmark against national metrics.	Allow staff to have the knowledge of our performance and feel pride in the job they are doing.	Provide assurance to our system partners of quality and safety indicators.
Patient Information Screens	Provide quality information to staff and service users.	Patients will have information that supports informed consent.	Staff will feel pride in seeing improved metrics and a greater sense of ownership.	Aligns with recommendation from recent CQC visit.
ImproveWell App	Harness staff insight to deliver the safest, kindest care and enhance staff engagement.	Use staff's deep knowledge of processes and estate to target improvements.	Staff have a greater voice are more empowered and able to influence service development.	SaTH will be able to give more accurate feedback to partners to focus investment to best effect.
Fertility Viewpoint scanners	Deliver updated systems.	Further enhanced image quality supports excellent care.	Empowered to give best possible care.	Fully compatible systems.

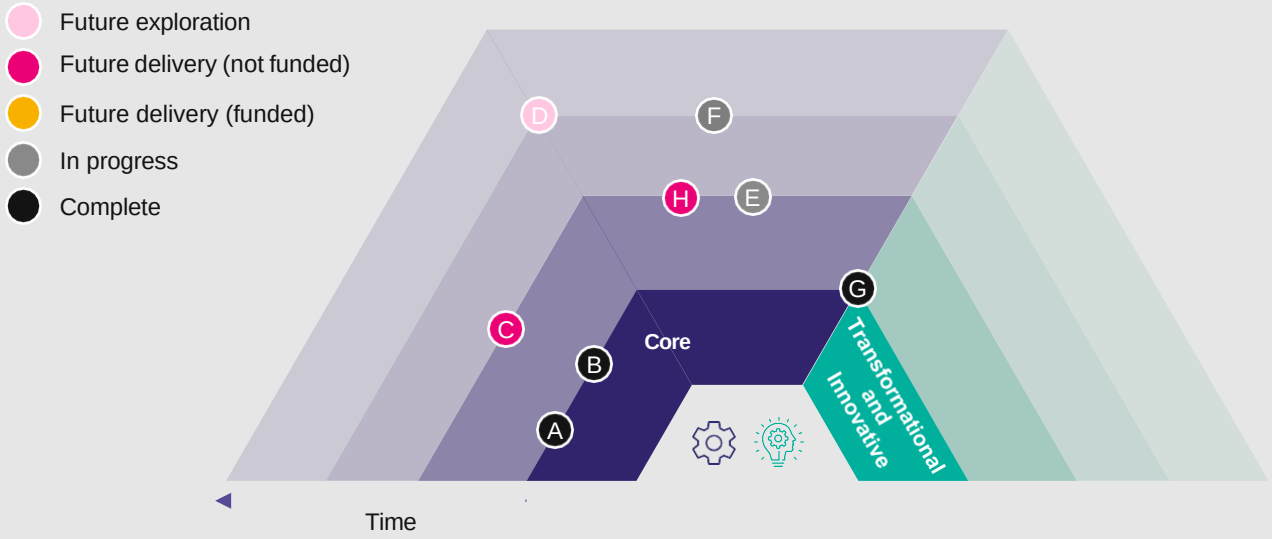
The digital transformation within maternity services aligns to our Trust's Digital Strategy

As set out in the over-arching Trust Strategy, the maternity services' plan and reflects the 7 success measures within the What Good Looks Like Framework[1].

Improved maternity dashboard data will allow divisional and service leadership to concentrate managerial support in the right areas and drive associated improvement.

Overall data quality will improve, enabling better peer-to-peer and national learning. Use of digital information screens will reduce paper waste and laminating, thereby driving environmental efficiencies. The platforms selected have market-leading cyber security features, thereby protecting patient data.

Many of these initiatives will make it easier for staff to voice there ideas and opinions, and enable managers to provide timely and well-structured feedback. Service users will have maximal access to information to empower them to make informed decisions about their care.



	What we will implement	What this will achieve	How this aligns to our Trust Digital Strategy
A	Ultrasound reporting and image management *(Viewpoint)*	Simplifying ultrasound image management, reporting and data gathering.	Records Management
B	Maternity records system *(BadgerNet)*	Giving mothers greater access to and more control of their pregnancy records or care notes through paperless records. Capturing and recording information for women antenatally and postnatally, as well as during the intrapartum period.	Records Management
C	Neonatal records system *(BadgerNet)*	Expanding the maternity records functionality to Neonatal services.	Records Management
D	Maternity Whiteboard	Introducing screens to share key information with clinicians 'at a glance' to improve patient flow, reduce errors and increase patient facing time.	Decision Support
E	Maternity Dashboard Maturity	Maternity information linked to National Maternity data set	Business and Clinical Intelligence
F	Patient Information Screens	Introducing digital screens to provide up to date information to patients about Maternity Services.	Access and Communications
G	ImproveWell App	Enhancing staff engagement and boosting morale, using the innovative idea hub, push notifications, pulse surveys and sentiment tracker features within the platform.	Not mapped to a MDF theme in the strategy, however, the initiative will support the Maternity Transformation Programme directly
H	Fertility Viewpoint scanners	System and scanners to support fertility management.	Not mapped to a MDF theme in the strategy, however, the initiative will support the Maternity Transformation Programme directly

[1]. What Good Looks Like framework - What Good Looks Like - NHS Transformation Directorate (england.nhs.uk)

NHS
The Shrewsbury and Telford Hospital
NHS Trust

The Shrewsbury and Telford Hospital NHS Trust

Reporting period:	Qtr 1 2022-23	Apr-22	May-22	Jun-22
PMRT	**Findings of review of all perinatal deaths using the real time data monitoring tool**	Stillbirths: 1 Late Fetal Losses >22 Weeks: 1 Neonatal Deaths: 0	Stillbirths: 1 Late Fetal Losses >22 Weeks: 0 Neonatal Deaths: 2 Year 4 Relaunch of CNST Incentive Scheme document was produced. A change has been noted that from 6th May 2022 onwards all perinatal deaths eligible to be notified to MBRRACE-UK should be notified within seven working days.	Stillbirths: 1 Late Fetal Losses >22 Weeks: 0 Neonatal Deaths: 0 All cases with this quarter were reported to MBRRACE within the required timeframe.
HSIB	**Findings of review all cases eligible for referral to HSIB**	May Quality Governance report with April data shows 1 x new SI reported for Maternity in April (stillbirth at 40 wks). Investigation will be led by HSIB. The incident has been uploaded to STEIS. Quality Governance confirm that to assure a more robust monitoring process, any HSIB action plans following the outcome of their investigations, are uploaded to Datix against the relevent incident.	June Quality Governance report with May data shows 3 open Serious Incident investigations ongoing for maternity, 2 of which are being investigated by HSIB. 1 x Closed Serious Incident - there were no safety recommendations from this investigation from HSIB. Learning regarding immediate pain relief needs and alternative analgesia methods, will be disseminated throughout the Division.	2 Serious Incident investigations remain open and ongoing for Maternity with HSIB. The final report from HSIB for the 1 x SI reported last month was approved by RALIG for submission to the commissioners for consideratin of final closure on 30/6/22. Learning of immediate pain relief was communicated to staff via a 3 Minute Brief document on 28/6/22 - an anaesthetist was present during MDT clinical incident review to discuss pain management in theatre.
INCIDENTS	**Report on the number of incidents logged and graded as Moderate or above and what actions are being taken**	11 x incidents were reported as Moderate Harm for April and remain at this level. 1 x incident has been fully reviewed and finally approved. No Moderate harm incidents are currently overdue for review. No severe harm incidents were reported. Where Moderate harm remains following the review, evidence of Duty of Candour is attached to each incident on the Datix system.	2 x incidents were reported as Moderate harm for May and remain at this level. 1 x reported and remains 'death not as a result of the incident' - 26/40 intrauterine death of a twin being reviewed via PMRT process. 1 x baby fall being reviewed as Divisional Investigation.	3 x incidents were reported as moderate harm for June and remain at this level. 1 x escalated appropriately (bladder injury) and management and care in line with guidance. 1 x baby readmitted with jaundice - delay in blood testing, escalated to a Divisional Investigation. 1 x reviewed as an Internal Investigation - patient had a history of recurrent headaches during pregnancy and after birth - CT scan diagnosed a sub-dural haematoma.
TRAINING	**Report on Training compliance for all staff groups in maternity relating to the core competency framework and wider job essential training.**	Maternity specific training continues to be transferred across to LMS, however, some issues are still being resolved and risks around compliance reporting continue to exist. Figures for face-to-face maternity specific training will be held locally on the Maternity Training monitors on the shared drive and will be used for CNST reporting until accurate compliance figures can be obtained from LMS. A number of courses have been booked for May/June/July with support from Ward Manager to remind staff of additional training available.	Relaunch of MIS Y4 from 6 May announced submission deadline extended from June 2022 to 5 January 2023. 90% compliance duing 18 mth period required, acknowledging Cov-19 pressures. The Trust Learning Management System (LMS) piloted since Nov-21 has some issues with registration, transfer of e-Learning data and training compliance figures - these have been highlighted with Corporate Education. A bespoke training package and funding for both equipment and external training courses has been developed to enhance local training. Training risks have been identified and mitigation in place where appropriate. Actions for areas with compliance below 90% have also been identified.	Current SSU compliance report is held by Corporate Education for reporting on Maternity Specific training directly from LMS. First report with accurate data in progress following manual data cleansing process. Available end of July. Maternity Specific Training Compliance figures as at 30 June reports training is largely on track. Action plan is in place to achieve required compliance with MIS Safety Action 8 for NLS training for all staff. Non compliant staff are known to Ward Managers and followed-up by the CPE team to ensure they are booked on to training to include Ad hoc sessions in clinical areas, within the required 12mth period. All staff are to be rostered to attend maternity face-to-face training. Sanctions for non-compliance under review by senior management team.
STAFFING	**Report on minimum safe staffing in Maternity Services:** **- Obstetric cover on the Delivery Suite** **- Midwifery - gaps in rotas - minimum safe staffing planned cover, versus actual**	Obstetric Data: Minimum safe staffing level on the obs unit for doctors is: Tier 1: One from FY2, GPVTS 1-2, ST1-2, equivalent/higher grade Tier 2: One from ST3-7, equivalent/higher grade Tier 3: Consultant covering obstetrics only (gynaecology has its own consultant cover at all times) During the day from 08.30 - 21.00 hrs all three tiers are resident in the building, from 17.00 hrs the Tier 1 and 2 take over cover for gynaecology as well as obstetrics until 08.00 the following day. During nights from 21.00 - 08.30 hrs all three tiers are resident in the building on almost all nights but occasional nights due to sickness may have the tier 3 as non-resident if the resident is the one off sick. On most week days, a second tier 2 doctor will cover obstetric triage from 08.00-19.00hrs. The plan is to extend this provision to the weekend also.	Obstetric Data: Minimum safe staffing level on the obs unit for doctors is: Tier 1: One from FY2, GPVTS 1-2, ST1-2, equivalent/higher grade Tier 2: One from ST3-7, equivalent/higher grade Tier 3: Consultant covering obstetrics only (gynaecology has its own consultant cover at all times) During the day from 08.30 - 21.00 hrs all three tiers are resident in the building, from 17.00 hrs the Tier 1 and 2 take over cover for gynaecology as well as obstetrics until 08.00 the following day. During nights from 21.00 - 08.30 hrs all three tiers are resident in the building on almost all nights but occasional nights due to sickness may have the tier 3 as non-resident if the resident is the one off sick. On most week days, a second tier 2 doctor will cover obstetric triage from 08.00-19.00hrs. The plan is to extend this provision to the weekend also. Midwifery Data: - CE in progress	Obstetric Data: Minimum safe staffing level on the obs unit for doctors is: Tier 1: One from FY2, GPVTS 1-2, ST1-2, equivalent/higher grade Tier 2: One from ST3-7, equivalent/higher grade Tier 3: Consultant covering obstetrics only (gynaecology has its own consultant cover at all times) During the day from 08.30 - 21.00 hrs all three tiers are resident in the building, from 17.00 hrs the Tier 1 and 2 take over cover for gynaecology as well as obstetrics until 08.00 the following day. During nights from 21.00 - 08.30 hrs all three tiers are resident in the building on almost all nights but occasional nights due to sickness may have the tier 3 as non-resident if the resident is the one off sick. On most week days, a second tier 2 doctor will cover obstetric triage from 08.00-19.00hrs. The plan is to extend this provision to the weekend also.

Appendix 2

Maternity and Neonatal Safety Champions Group
Locally Agreed Safety Intelligence Dashboard

The Shrewsbury and Telford Hospital NHS Trust

Reporting period:	Qtr 1 2022-23	Apr-22	May-22	Jun-22
SERVICE USER FEEDBACK	**Service User Voice feedback**	Maternity Transformation Programme Team reported the following progress for April: •Devised a format for a larger scale birth preferences card to be displayed on the walls of birth rooms. •Communicated to health professionals to ensure that conversatons between colleagues should include the woman involved.	Maternity Transformation Programme Team reported the following progress for May: •Devised plan to manage how informaton is fed to users of BadgerNotes to help them not feel overwhelmed •Created a 'Who's Who' of consultants for the website	Maternity Transformation Programme Team reported the following progress for June: •Included a checkbox on Badger for contnuity discussions. •Commenced the creaton of infographic for social media to display maternity related data to service users.
STAFF FEEDBACK	**Staff feedback from frontline champions and walk-abouts**	Walkarounds took place in the Antenatal Ward, Day Assessment Unit and Triage areas during April. Action re. limited number of triage beds in Antenatal ward is ongoing and tracked on Safety champions action log. Plan to present paper next Risk Register meeting and all options for alternative triage locations are being explored with LMNS oversight. Problems regarding privacy are also being addressed.	No walkabout scheduled for May, as three areas were visited in April. Additionally, it has been noted that areas are suffering from 'walkabout fatigue' following the publication of the second Ockenden report.	June meeting stood down due to quoracy not met and unable to reschedule due to unavailability of Chair and DoM. Theatres area to be visited in July and Postnatal ward the following month. Due to the three areas visited in April, it was thought the bi-monthly requirement for CNST is not compromised. A plan for all further visits is in progress.
EXTERNAL AGENCY REQUESTS / CONCERNS	**HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust**	No requests for action have been made directly with the Trust fro HSIB or NHSR.	No requests for action have been made directly with the Trust fro HSIB or NHSR.	There has been 1 x CQC request June. No requests for action have been made directly with the Trust fro HSIB or NHSR.
CORONER REGULATION 28	**Coroner Reg 28 made directly to Trust**	No Coroner Reg 28 made directly to the Trust	No Coroner Reg 28 made directly to the Trust	No Coroner Reg 28 made directly to the Trust
CNST SAFETY ACTION 10	**Progress in achievement of CNST Safety Action 10**	1 x case repoted to HSIB. All qualifying cases reorted to MBRRACE and PMRT commenced in with CNST and compliant with timeframe.	All qualifying cases reorted to MBRRACE and PMRT commenced in with CNST and compliant with timeframe.	Quality Governance report that families have received information on the role of HSIB and the EN Scheme where applicable. Duty of Candour is up to date with all cases.

CQC Maternity Ratings	**Overall**	Requires Improvement	**Caring**	Good	**Safe**	Requires Improvement	Trend: improvement year on year
	Well-Led	Requires Improvement	**Effective**	Good	**Responsive**	Good	

Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Reported annually)	TBC - data not yet available
Proportion of specialty trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how would they would rate the quality of clinical supervision out of hours (Reported annually)	89.06% (source: GMC National Trainees Survey 2021, Appx 13)